20220517 EMS Financial Health Committee Minutes (Draft)

Tuesday, May 17, 2022 10:30 AM

Meeting Subject: Maine EMS Financial Health Committee Meeting
Meeting Date: 5/17/2022 10:30 AM
Location: https://mainestate.zoom.us/j/86555349353
Link to Outlook Item: *click here*
Invitation Message
Participants

- *Note: Minutes have been excerpted and edited from the recording transcript.*

Agenda

1. Call to order 10:33
2. Reading of the Maine EMS Mission Statement

"The mission of Maine EMS is to promote and provide for a comprehensive and effective Emergency Medical Services system to ensure optimum patient care with standards for all providers. All members of this Committee should strive to promote the core values of excellence, support, collaboration, and integrity. In serving on this Committee, we commit to serve the respective providers, communities, and residents of the jurisdictions that we represent."

For those that are new we read that mission statement at the beginning of every one of our meetings and we try to be reflective of that in our in our proceedings

3. Attendance

- ☑ Davis, Darren W (Staff, Non-voting)
- ☐ Andy Turcotte, Paramedic - Maine EMS Board
- ☑ John Martel, MD, Ph.D - Maine EMS Board
- ☑ Joseph Kellner VP – Finance, Operations & Strategy - Maine EMS Board
- ☐ Joseph Spicuzza - Not for profit Health Plan (CONFLICT)
- ☑ Karynlee Harrington (Karynlee.Harrington@maine.gov)- Maine Health Data Organization
- ☐ Katherine Pelletreau (KPelletreau@MEAHP.com) - MeAHP Representative (CONFLICT)
- ☑ Kimberly.LaFauci@Cigna.com - Non-voting party of interest (Director of Contracting CIGNA)
- ☐ Kristine Ossenfort - For Profit Health Plan (CONFLICT)
- ☐ Michael Senecal - Rural non-municipal transporting ambulance service (CONFLICT)
- ☑ Rob McGraw - Rural municipal transporting ambulance service
- ☑ Robert Hillman - Not-For-Profit Health Plans Based in Maine, Community Health Options
- ☑ Robert Russell III - Maine Ambulance Association Representative
- ☑ Scott Guillerault - Non-Transporting Ambulance Service
- ☑ Shawn Esler - Non-Rural Municipal Transporting Ambulance
- ☑ Stephen Almquist - Non-Rural Non-Municipal Ambulance Service
- ☑ Thomas W Bell (Thomas.W.Bell@maine.gov) - Department of Professional and Financial Regulation, Bureau of Insurance

Public
Polly Wood
Aiden Koplovsky

4. Prior Minutes
   a. Minutes for 20220310
   b. Motion to accept: Thomas Bell
   c. Seconded by Butch Russell
   d. Vote

- ☐ Andy Turcotte, Paramedic - Maine EMS Board ABSENT

- [x] John Martel, MD, Ph.D - Maine EMS Board
- [x] Joseph Kellner VP – Finance, Operations & Strategy - Maine EMS Board
- [ ] Joseph Spicuzza - Not for profit Health Plan ABSENT
- [x] Karynlee Harrington (Karynlee.Harrington@maine.gov)- Maine Health Data Organization
- [ ] Katherine Pelletreau (KPelletreau@MEAHP.com) - MeAHP Representative ABSENT
- [ ] Kristine Ossenfort - For Profit Health Plan ABSENT
- [ ] Michael Senecal - Rural non-municipal transporting ambulance service ABSENT
- [ ] Rob McGraw - Rural municipal transporting ambulance service Abstain
- [x] Robert Hillman - Not-For-Profit Health Plans Based in Maine
- [x] Robert Russell III - Maine Ambulance Association Representative
- [ ] Scott Guillerault - Non-Transporting Ambulance Service Abstain
- [ ] Shawn Esler - Non-Rural Municipal Ambulance Abstain
- [ ] Stephen Almquist - Non-Rural Non-Municipal Ambulance Service Abstain
- [x] Thomas W Bell (Thomas.W.Bell@maine.gov) - Department of Professional and Financial Regulation, Bureau of Insurance

a. Minutes for 20220413
b. Motion to accept: Robert Hillman
c. Seconded Thomas Bell
d. Vote
- [ ] Andy Turcotte, Paramedic - Maine EMS Board ABSENT
- [x] John Martel, MD, Ph.D - Maine EMS Board
- [x] Joseph Kellner VP – Finance, Operations & Strategy - Maine EMS Board
- [ ] Joseph Spicuzza - Not for profit Health Plan ABSENT
- [x] Karynlee Harrington (Karynlee.Harrington@maine.gov)- Maine Health Data Organization
- [ ] Katherine Pelletreau (KPelletreau@MEAHP.com) - MeAHP Representative ABSENT
- [ ] Kristine Ossenfort - For Profit Health Plan ABSENT
- [ ] Michael Senecal - Rural non-municipal transporting ambulance service ABSENT
- [ ] Rob McGraw - Rural municipal transporting ambulance service Abstain
- [x] Robert Hillman - Not-For-Profit Health Plans Based in Maine
- [ ] Robert Russell III - Maine Ambulance Association Representative Abstain
- [ ] Scott Guillerault - Non-Transporting Ambulance Service Abstain
- [ ] Shawn Esler - Non-Rural Municipal Ambulance Abstain
- [ ] Stephen Almquist - Non-Rural Non-Municipal Ambulance Service Abstain
- [x] Thomas W Bell (Thomas.W.Bell@maine.gov) - Department of Professional and Financial Regulation, Bureau of Insurance

5. Public Comment

a. none

6. Modifications to the agenda

a. None

7. Old Busines

a. Overview of the committee
   i. Joe Kellner: Where we have some new members, just a quick orientation to the work we're doing here. This is a subcommittee of the Maine EMS Board. That can be a good thing and a challenge from time to time, we do have some rules under the administrative procedures act that we have to operate within. The first in the one that I think is most important, as all of our proceedings, need to be transparent and open to the public, with few exceptions. So we cannot conduct any business outside of our regular meetings that means members of this committee can't work on projects aside or anything like that it's all going to be done in public session. If you do have thoughts ideas, etc, the best practice is to send those to Darren. Darren can send things out to the committee to review ideas, thoughts etc in advance. But we do conduct our business here. We will meet, regardless of whether we have a quorum or not, the lack of a quorum, which is a majority means we cannot vote on any items.
b. Change pending for the committee makeup
   i. Kim to be seated as a voting member
   - [ ] Joe Kellner to request board to add a seat for adding an additional seat for **For Profit Health Plans**
   ii. Karynlee to be a non-voting member
   - [ ] [Joseph Kellner] follow up with Maine EMS board of to be ex-officio member

c. Introductions

d. Review legislative language on committee deliverables
    i. Joe Kellner provided some background information:
    The work for today really originates out of legislative directive that originated out of a prior committees work with recommendations and legislature and reimbursement for emergency medical services. This all goes back to the surprise billing law that was passed in Maine about two years ago. Especially noting how few in network contracts existed between ambulance services and commercial carriers. What came out of the committee's recommendation were a handful of items. The real goal, though, was to increase network participation of the ambulance services with carriers in the state of Maine.

    I think we're two years out now from enough. and basically it says that. kind of surprise bills for any emergency medical treatment, it was identified that ambulance services aren't a bit of a unique position. Especially noting how few in network contracts existed between ambulance services and commercial carriers anthem, by far, had the most in network, I believe there were. 40 or 50 that were in network, the remainder of the carriers averaged eight ambulance services with whom they were in network. What came out of the committee's recommendation were a handful of items. The real goal, though, was to increase network participation of the ambulance services with carriers in the state of Maine. Other things that this accomplished was a report to the department, health and human services that request are required that MaineCare add on the rural and super rural modifiers for care that's delivered in those areas. That could mean an increase of 3% or 22 and a half percent depending on the care is delivered by MaineCare. Incidentally, the same requirement of legislation was passed on to the commercial carriers to recognize these rural and super rural areas. Cost reporting was another piece that came out of that, directing the board to establish cost reporting mechanisms for ambulance services in the state. And kind of a thematic outcome from that committee's work was really starting to think about the efficiency, or lack thereof, and the delivery model in the state of Maine. I think it's important to note at my last count, we have 165 transporting services in the state of Maine. The majority of those are not doing anywhere near enough calls to cover costs of providing the service, which requires subsidy from somewhere. What we don't have in the state is our arms wrapped around how that looks from area to area from service to service. And we don't really have a great understanding on how services are sustaining operations; successfully continuing to serve etc. We know anecdotally that many services rely on subsidize. We know that services historically have relied on offsetting losses on government payers with commercial carriers. We know that in some areas, hospitals have begun subsidizing facility transports to increase reliability. But we also know that services are not stable necessarily for the long term and that's a universal statement but it's broad and wide reaching.

    We also talked about all of the other legislation, looking at innovative models, how we implement innovative models, some of those include reimbursement for treatment without transport and looking at Community Paramedicine. We talked about reviewing issues related to medical necessity and reasonableness of ambulance services.

    Then ultimately reporting to the legislature, with our recommendations, the legislature that is authorized by the bill to create another piece of legislation that looks at these items. So, from a timeline perspective, we have to have that report, right now, as the HCIS committee health coverage insurance and financial services, no later than Feb 1, 2023.

    There are a couple of items that have been discussed her dress by both the board in the medium is office that are relevant to this work. One of which has to do with cost reporting the office responded that they're not opposed in as the Maine Bureau of EMS is not opposed to be implemented cost reporting. It was determined as part of the conversations around that that the Maine EMS would be the best place to house that regardless of what our opinions may be on that that was the direction in speaking with the director and the Commissioner. I will note in the legislative directive that any implementation off cost reporting is contingent upon allocation of resources to be able to fund a position or positions in the office that can focus on cost reporting and getting people hired that are that have experienced in cost reporting accounting, you know getting that expertise in the office. What we need to do, as a committee on the cost side of finance side is think about a making sure that we have language and whatever legislation developed that goes to appropriations to fund that and we'll need the offices input and what they actually determined that they need so will be dealing with the appropriations Committee, as well as part of this always an adventure. The bigger piece here is that we will need to determine what we do with that information, on how that information affects payment issues, how it affects operational issues, etc, so that'll be that'll be critical. The other piece, has to do with quality of ambulance services, it was discussed previously that we know that not all ambulance services are created equal. Levels of care, etc, vary what ambulance services are doing with their mission does very place to place and there is a desire to have some measurement of that as we as we go through this work.

    Robert Hillman: That was a lot. It takes me back to the work group obviously and all the dialogue we had around many of the tough issues. This particular committee isn't tasked with solving all of that it's tasked with trying to get the fundamental data and reporting to the legislature, so that at a certain point, we know what the financial health, underlying cost, underlying efficiency is of the services. So that we decide whether or not we're going to continue to mandate a rate of payment or do something new. So I just wanted to just want to make sure what's achievable in the next six to nine months or less right because if we're only meeting once a month I don't know how we tackle anything but that mandate.

    Joe Kellner: If you look at the agenda item7 d that's really a high level extraction of what the requirement is in the legislative directive. Then Rob is correct, this this work will inform our lead other work down the line. Rob is there anything I missed or anything that you want to add from the previous committee work that you think we should be looking at in this committee.

It is entirely possible I missed things.

Robert Hillman: That was a pretty comprehensive review Joe that you had. I can't point out anything specific that was missed. Here's my of carrier view, if there's a service that doesn't have enough transports right to cover the costs and that has to be subsidized. We have a guaranteed rate payment for a period of time that's subsidizing those costs and it's the private payers that are carrying that cost. The question is where should that subsidy come from. But you know we're not going to make that determination, but we should make the determination around what is and what should a relative level of efficiency should be if you're going to run a transport service. What's the best level of efficiency you should be able to achieve, and then what does that cost and what is that cost plus margin. That's to me kind of what we have to get to because that's going to set the level of subsidization and where that comes from is going to be that cost plus margin. So sorry, I'm probably leaping already into where we kind of go right because you know I don't think you're going to solve all the fundamental problems, but if you're going to subsidize something you got to know what it costs.

Joe Kellner: I mostly don't disagree, the only you know, the only piece that I would kind of grab on to is that since we met before, and since this work was done before, the cost has dramatically increased and that's global across healthcare and none of us are naive to that. So we set that metric and that benchmark and it was it's kind of stale already so to your point rob, I think, is that one of the things we want to think about is some sort of method that ties cost to reimbursement and transcends time. And we don't have that yet. I do hope everybody's familiar with the Medicare costs reporting requirement for ground ambulance services. That is still being established. It only applies to transporting services. And our industry hope there is that Medicare will eventually do what they do with other areas of health care and start to tie some of their reimbursement back to cost. The inherent problem with that and cost reporting is that is time delayed. Hopefully someday the government payers are closer to costs. We know that in the before times, as I like to call it before COVID, Medicare tended to be about 85% of cost and MaineCare was less than that, and as the costs have risen and reimbursement hasn't.

ii. **Review of financial health and costs of ambulance service providers and the delivery of services by ambulance service providers.** The Emergency Medical Services' Board shall convene a stakeholder group, including representatives of the Maine Ambulance Association, municipal and private ambulance services, health insurance carriers and the Department of Professional and Financial Regulation, Bureau of Insurance, to review issues related to financial health and costs of ambulance service providers and the delivery of services by ambulance service providers in this State, including issues related to the medical necessity and reasonableness of ambulance services. The stakeholder group shall consider and develop financial and cost reporting standards and other metrics related to the delivery and quality of ambulance services to measure and evaluate ambulance services in this State. The Emergency Medical Services' Board shall submit a report on the results of its review, including any recommendations, to the joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters no later than February 1, 2023. The joint standing committee may report out a bill based on the report to the First Regular Session of the 131st Legislature.

e. What would work product look like (From 3/10 meeting) :
   i. Cost Reporting

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anyway so let's start with the first piece. we'll dive right in here reviewing issues related to the financial health and costs of ambulance service providers and delivery of services.

Joe Kellner: We have made the suggestion of implementing a State cost reporting platform, this would require a minimum all transporting ambulance services to submit cost reports at some regular interval to the state of Maine. I want to actually ask directly, especially for the service representatives on the phone, but for anybody do folks still feel like that is a good idea and the right way to go.

Rob McGraw: I think it can only have to give us a baseline so it's almost a necessity to start somewhere.

Joe Kellner: Thanks Rob. Any other thoughts.

Butch Russell: I mean, I would agree. I think this is a good starting point. It', the only way that we can really, from my perspective, I guess what kind of trouble, the industry is in is to show the cost and the cost report is probably going to be the number one most important thing that comes to this.

Joe Kellner: I'm going to ask it kind of the reverse does anybody disagree with continue to pursue cost reporting for transporting ambulance services. Let's talk a little bit about scope, so it is unclear whether or not non transporting EMS services are included in this or in scope. How do folks feel about that piece. Should we be collecting cost report data from non transporting EMS services.

Scott Guillerault - Ellsworth FD: I think, fundamentally, we have to figure out what it is what it is costing non transporting because there is no cost recovery for them.

Shawn Esler: We definitely should implement some kind of a cost reporting for non transport agencies, because they are essentially what completes the EMS system as a whole, like Chief Guillerault said earlier, the cost recovery mechanisms for non transport isn't there yet they are so critical to our system.

Joe Kellner: Does anybody disagree that non transporting services should be included and cost reporting to do.

Shawn Esler: And then I would point out, is what the report actually looks like because we're asking our agency leaders, not only to run an organization to report out to Maine EMS. For a lot of us it's going to be fairly simple as it relates specifically to municipal services. The difficulty comes in evaluating fire protection verse EMS and what breakdown actually supports the EMS system versus fire protection, so I would just throw out there that I would be interested in working on how that report is actually presented.

Joe Kellner: That's an excellent point and it's certainly a challenge that we discussed last time is allocation of cost. It gets especially complicated when you have what I refer to as ready time that could be applicable to the fire side or the EMS side so coming up with a way to allocate those causes is absolutely critical. The other big thing is it's really going to be consistent in that you know. Your other your other point that I believe you were making as well is that is a matter of time and expertise, if you look at the Medicare costs reporting requirements it really does require accounting, billing, financial expertise and you know, we do have to be mindful that. As far as transporting service cost reporting goes I kind of see to two pathways Massachusetts took one pathway and they've been doing cost reporting for quite some time, there are closest neighbor to do it. Massachusetts implemented statewide ambulance service cost reporting several years ago and they're going to be continuing to operate with two separate tools, so I use that preface to say we have the option to utilize the Medicare tool or we have the option to develop a State tool. I don't think we'll have an option for the non transporting services, I think some tool will have to be developed, internally. But my question for the group for the transporting services that hopefully have looked at the cost reporting requirements for Medicare. Do you feel we should just simply use the same cost reporting tool, or do you see any reason that we need to develop our own tool.

Butch Russell: Can we get our hands on the Massachusetts cost reporting? I think, Tom judge sent that out. I remember seeing it like two years ago.

Joe Kellner: I'm making a note. I'll make sure that gets circulated. Also it occurs to me I failed to circulate the 2105

material so make sure that goes as well.

Robert Hillman: I'm going to be typically quiet in this space, because I think the delivery services are much closer to the requirements of cost reporting and what goes into it and the tools, but I would say that. Obviously, each transporting entity is maybe slightly different town right versus not for profit versus private ambulance services, so we got to get them in cohorts right so i'm assuming that the tool does that, in other words. You got to get apples to apples right to get cohorts that you can compare to.

Joe Kellner: The Medicare tool does accomplish that for sure. I'm not sure on the Massachusetts tool that I will circulate. rock, can I ask you a question and. Sorry, to put you on the spot in Kim feel free to jump in here as well, I think two carriers that are representative over on the screen. Are you currently is there anything we can learn from are you using cost reports for raid setting for any other areas of health care that exists currently.

Robert Hillman: There's certainly rich data around the cost of health care in the public domain, plus, you have the every carrier has its own data set from claims and utilization from membership it carries in various lines of business. The problem tends to be in Maine in a highly you know fee for service dominated state, especially when you when you deal with complex institutional care is trying to drill down into what's actually being billed for and what is the cost basis of what those items are. That really is the crux of all healthcare which is what is the direct cost of the item that that is going into a component thing, whether it's you know ambulance transport or a surgical service. That is my long winded way of saying we do that to our best of our ability, and we, and when we do it we benchmark it to Medicare. Medicare is the baseline right. Medicare is X call that 100% of Medicare and then we benchmark all of our professional institutional payments and costs on a multiplier that.

Joe Kellner: What I was going to ask is for ambulance services in particular. Is it a fair statement to say you lack comparable data. to other areas of health care to make those assessments and determinations.

Robert Hillman: And for the legacy relationships, may have been pushed closer towards Medicare standards, which you know, what I'm hearing is Medicare doesn't cover costs. I don't think you're going to find broad agreement in the payer classes that that's a true statement in every case. If you're going to pursue that and you're going to say well Medicare doesn't cover my costs and I have to cost shift, then you really get down to what is that marginal cost. You know 100 times X, 200, is it 300 and that's really the pressure we're under which is to understand is that the true nature of the cost shifting and is that over cost shifting. Right and so getting down to the sort of the nuts and bolts of the service being transparent about it. When you're in a you're in a legislatively mandated reimbursement position I believe that the delivery system that's getting the benefit of that should be transparent about their direct costs.

Joe Kellner: No disagreement. I think that there is, to some degree, some transparency, certainly municipal budgets and performance are transparent and we have the nonprofit world love their 990's. Which can be telling. But I know you suffer from the same affliction Rob, so it. there's some data out there but what I'm hearing is kind of universal agreement that we need more information on on what the actual costs are and how it varies by service type by location, etc. I think that part is universally true and further you know what I'm hearing from this conversation is that EMS is different from other more traditional areas of health care in the visibility of the data surrounding those costs.

ii. Develop some standard for the issuance of new service licenses

Robert Hillman: and Joe one last thing, people are going to see my style here pretty soon too which is I'm as passionate as you are about all things health care in terms of trying to mitigate the spiraling costs care. But there is a variation in care that we see a lot and that variation in care is hard to understand. When I think about the work we did in the subcommittee the takeaways I had were that we had a concentration, or maybe an over concentration, of services in certain areas of the State and an under concentration. That you didn't have the right distribution of resources amongst the 160+ services and then there is variation in the application of how the services are delivered to the. In medicine that's rampant in terms of that differentiation, variation, in the care you receive, and so I think it's important to try and come to grips with that as well are we delivering the services as efficiently as possible, do we have the right servicers in the right place and what do you do if you're doing this at the State level and almost like a planned development way, what is the process to go into and stand up another service line if you already have a concentration of servicers.

Joe Kellner: I'm glad you mentioned that, because that does become somewhat in scope for this conversation. That was a directive to the Maine EMS Board to establish some standard for issuance of new licenses and that's kind of been. I think well it's not really been addressed there's been a grant process for the ICSD program but that's really been the only thing we've seen out of that. The hope there was that comes out of Maine EMS strategic planning. But we did talk a good deal about that. What are the standards for standing up a new service and part of those standards reflect on the current either over or under saturation of other services, making sure that people are getting the care they need. So that directive is out there, it probably will continue to live with strategic planning based on how the legislation was written, but we can certainly add input into that.

Rob McGraw: I think it depends on how we're going to define some things. Services offer ambulance coverage but some our full time staff at the station, some are volunteer where they drive in and on an insurer perspective that cost recovery, it costs more for me to have people at the station 24 hours a day than it does for a neighboring department to have people sitting at home paying them $2 an hour. So their costs are going to be different, even though my deliverable could be measured the same because we're still taking a patient from point A to Point B, but time response quality is one of those subjective measurable that we have to try to figure out.

Butch Russell: This may sound somewhat ignorant, but is it this committees job to actually come up with a tool, or is that going to be directed to Maine EMS.

Joe Kellner: No this committee will provide some guard rails or guidance or go to legislature to suggest what we might want to see in the tool or from the tool, but the way I picture this going is that if we get the positions funded at Maine EMS the goal will be to get experts that can determine what they need to get to the reporting that we need. My personal leaning would be to recommend that they just adopt the Medicare tool, and the reason for that is it's one less thing for services to have to do because we're going to have to do that anyway, it just doesn't cover the non transporting services so hopefully that answered your question but that's kind of what we're getting to, not building something from.

Butch Russell: It's also collecting not just cost, but also revenue. So what are the services getting. I know municipal services are a little bit different, is fully tax funded, but something like northeast where we also collect probably for our ambulance services line it's probably a 1, 1.5 to 1.75 million a year in subsidies, just to keep the doors open. There's huge percentage that are the those are the taxpayer still but asking what those numbers are. The other thing that kind of comes to mind is where we have some scale and efficiency, because we're larger but our volumes actually decreasing now to the point where it's hurting us but looking at this, maybe not as a system, I think we're looking at a service like northeast it's almost splitting this up per division, so we are offering four divisions there's some efficiencies management, and you know HR and insurance and stuff but also see that each one of those faces is really has a different metrics and different cost per trip, and you know costs associated with them and different subsidiaries come from either hospitals orm municipalities.

Joe Kellner: Okay, good points, so we've got some stuff to work with their to develop some recommendations. What I'm going to need from Maine EMS, and Darren I can talk to Sam about this offline and it might be good if he's able to join our next meeting, but really need the EMS office to evaluate what resources they feel they need to accomplish cost reporting review internally and provide the support services to complete that because it is going to be a body of work for sure, and we want to make sure that we have that established well is we go to appropriations ask for money to fund that position long term are those positions.

iii. Medical Necessity

Joe Kellner: As a committee, we have the opportunity to go back to the legislature and say you know actually we think everything's fine here, no changes need to be made, I will admit that this ended up in the in the legislation from. LD2105 as part of what I think was a very brief conversation at that committee, but it did get picked up. I'm curious, both from the carrier perspective and the ambulance service perspective, what you think we should be addressing here related to medical assessing reasonableness as it applies to the variation between payers.

Rob McGraw: On our end it's a lot on hospital education. We go to take a patient and the hospital deems that because I'm a doctor, this patient needs to move even though CMS clearly states that it doesn't matter the doctor's opinion it's. You know X, Y and Z and we try to educate the hospital and as our local hospitals said my need for getting recovered from cost, it's not their concern.

Shawn Esler: One the areas that I see probably costs is as it relates to mental health, and while I'm not prepared to have the discussion today. I do think that there's an ambulance is overkill for some of these calls and we're overbuilding in some circumstances for mental health responses, whereas a smaller vehicle or even a police vehicle could be you know have some assistant and moving patient from point A to point B.

Rob McGraw: I came from a state where we had a mental health transport cars. We called it a cage car. It basically an unmarked police car with an EMT basic who would drive it. They would do a set of vitals at the facility. Patient was cooperative. It was only for adult patients not for pediatric patients. They would drive them to whatever facility they needed to go to. Do another set of vitals and had some basic equipment in there in case there was an issue. It was a huge burden off the ambulance because you're not taking the ambulance. There is legislation out there in many other States of cage cars or mental health, transport cars that doesn't fall under the guise of the ambulance service. A lot of these patients don't need a full ambulance crew, they really just need the ability to get there, and make sure they get there.

Thomas.W.Bell: There's got to be a better way, so I really like that idea of the transport cars and things like that that are designed with that in mind.

Joe Kellner: On the medical necessity for transport side, you know that I think we all kind of know the documentation requirements for Medicare and MaineCare. There's variation with the carriers. The commercial carriers for sure. I kind of go back to that question, do we think that we would benefit from exploring this area more deeply or again if folks don't think it's an issue that's a perfectly appropriate response as well.

Scott Guillerault - Ellsworth FD: Forgive me, because I've been out of State for several decades. But. aren't most of the private carriers doing preauthorization now prior to services doing transports.

Joe Kellner: So you know my experience across carriers, is it varies in how its implemented. The majority of prior auths, it's a bit counterintuitive, it's a retro prior auth that happens, there are some carriers now requiring a true prior off, but those requirements do vary widely from carrier to carrier.

Robert Hillman: I can answer for us guys. Which is, we would prefer advance notice for non-emergency medical transport, especially if there's enough planning in advance because there's a variation in cost and there's also sometimes a variation and the expectation of where the transport is going to and from. We see odd behaviors where there's agreements to transport patients between inter-facility like from an Inpatient setting to an ambulatory site to get an image and then back that we never understand how that works and why it occurs. Versus I really need to transport on a non-emergency basis to a higher level of care, I just want to plan for it. But we want to talk about where is that going so we can authorize that on our side of care. The carrier really wants to just to get involved in the decision of the transport and that's why the advanced prior authorization is helpful. We do obviously take the retro auth into consideration if you just, for whatever reason, even though it's non-emergency, just can't get to it. I think we give you 10 business days to do the retro auth, so we can get it in our systems. But from a medical necessity basis, we're looking at we're trying to look at for national standards we use Milliman guidelines, we use CMS guidelines, we don't necessarily look at the state. But we're trying to do our best to create wrap around that prior authorization. The medical policy around it that guides our nurse care managers when to say yes, when you say no. So there might be real power in getting the carrier's together, who operate in the State of Maine to agree on a single set of conditions there. The problem you may have, though, is some of the carriers are domiciled in many areas and they're running multiple states, so it may be hard for them to pick out one State and say I'm in 16 markets and I'm going to do something slightly different so I'm just rate raising my hand on the carrier side, that may get weird. But I think there's some real power in promoting that. We promoted a monolithic payment rate for in and out of network, so why wouldn't we promote at the legislative level a single set of medical policies as well.

Joe Kellner: I'll show my cards for a second I, I agree with you. Where my head was kind of been at with this whole thing is that from a service perspective having one set of guidelines for necessity and reasonableness and one kind of fixed pathway to handle those makes a lot of sense. I personally feel that in this particular area Medicare is actually quite mature in how they define medical necessity and reasonableness and I think that intentionally or unintentionally gets applied to commercial carriers. There's not necessarily a standard in place so Medicare's definitions are actually pretty darn clear on what qualifies and doesn't as well as the documentation requirements. One thing I would advocate for is us potentially adopting Medicare guidelines universally for determining reasonableness and necessity and if it would be helpful for everybody, as we talked about this, I can circulate documentation on exactly what those regs are. But that's just my opinion, I feel free to disagree with me.

Scott Guillerault - Ellsworth FD: My concern would be clarifying those of us who are municipal services, providing 911 responses and those of us who are providing also inter-facility transports, not just necessarily a private service system.

Joe Kellner: Agree, it would have to be a standard that could be applied in each of the circumstances for sure.

Butch Russell: It's really tough on an ambulance service sometimes to navigate prior auths, which is why a lot of the carriers, I think, to the putting the prior auths after the transport or it's just if we're going to go down the road of doing the prior auth and, you know, having more carriers use prior auth, I think we have to acknowledge that we've got to bring the hospitals and health systems into this. It's really got to be on them in almost every case the ambulance service is not involved in any decision or even knows about the transport until ninety minutes to two hours before for the patient goes and it's at that point it's really tough for us to navigate that system. You know, and you talk about increasing costs know if we if we had to implement mechanisms to 100% of the time have prior auths with the with insurance carriers it would be very, very difficult and probably slow the system down drastically.

Joe Kellner: I agree with you, but and it's got to be really health system driven I mean I think care management is very used to attaining prior authorization for other types of services, skilled nursing comes to mind when there's a discharge, you know there's a whole pathway of things that occur. If we put the patient at the Center of all of our discussions which we always should, I do see a benefit in a better prior authorization process. If we focus on the patient, that they should be aware that they're transport is covered, and their out of pocket will be likely this and etc before they embark on that journey to wherever they may be going on a non-emergent basis. On the other hand, we also want to make sure we don't put up any barriers to time sensitive acute illness being moved from one hospital to

another. If you apply the Medicare closest appropriate guidelines and you can then probably eliminate the need for prior auth for higher level of care transports if it's to the closest appropriate facility. For the non-emergent, for the behavioral health, I do think there's actually good value in prior authorization and obtaining.

John Martel: I think the challenge is the system historically was designed as primary 911 response, and then there was this other arm for inter facility transfers. There was sort of a niche that was out of the municipality and I think we certainly do, given the COVID landscape, we sort of have to think hard about what this means in terms of expanding the use because primary 911 services are now being used for transfers. They're being used for behavioral health or potentially beings used for street level response you know leave behind Narcan so there's just a lot more layers than there was before, so I guess the question is it well, I think what we all agree on, is that we're potentially moving into a world where there is much, much higher use than ever and that's sort of predicated with higher cost than ever and potentially less reimbursement and available resources than ever, and so, how do we stratify and I think that sort of things a little bit back to sort of the pre authorization discussion and I defer to my sort of insurance industry, and you know sort of private and municipal colleagues on the call for what that looks like but from a hospital standpoint I think what's challenging for us is even without the current human resource shortage it's getting folks between hospitals, it's getting folks back to the nursing home at two o'clock in the morning and what service should be used for which of those and how long should want to expect to wait, and I think that's the problem, because you can't have the municipal service going to the group home for behavioral emergency at the same time that they need to be somewhere for a cardiac arrest, at the same time that somebody needs to go to Boston for a road transfer. And one thing that certainly come up in the last six to eight months or so as our resource has been a problem, both from services and human resource is do you start using air more than currently and I think the answer is definitively no because of very, very high cost of that. But some of the things that we've never really had discussions about have certainly popped up you know so should it take five days to get somebody from Presque Isle down to Portland you know with something like an NSTEMI, it probably shouldn't. So I guess the question is the prioritization and what the financial underpinning of that is. Who gets the transport right now? How much does that cost? How acute is that and sort of determining that priority and then what other level of transport is there that may be somewhat less acute. I'm probably speaking a little bit out of my depth and quickly getting into the world of sort of where many of you have expertise that I do not. But I think from us, we're just having difficulty getting patients to us and difficulty getting patients to back to where they belong. And I know that some of that needs to happen right away, and then some of that doesn't need to happen right away, and the cost is probably going to have to be different. Does that make sense?

Joe Kellner: Certainly does to me go ahead Rob.

Robert Hillman: It was great to listen to you talk about it Doctor Martell and then the first thing that pops to mind is if the payment problem driving the lack of resources or the structure of the resources and the need to stand up more or redistribute the resources so, is it the chicken and the egg. What's driving the ultimate problem? So I don't know. If all of a sudden we covered all costs plus margin do we still solve the problem you described in terms of being able to mobilize and loop patients and have the service levels were there a fully equipped ambulance or a car, you know, that you just described available. This comes back to my question about what is the landscape, where are the resources, how are they being used, are they being used efficiently right and is that a big part of what we need to be figuring out. Not just the cost and the financial carry but the efficient use and distribution of resources.

John Martel: I do think quickly that's a great point so when I started in Fire/EMS in the very early 2000s, there was a very different landscape in terms of how many trucks had BLS providers and did not have paramedics in it. It does sort of feel like over a 20 year period, or so, we maybe drifted towards. resources that were kind of at the higher training level end. But we don't necessarily need those resources for many of these transports. And it seems like there's some cost reflection in terms of what kind of what's the acuity of the care delivered, who is best to deliver it and does that free up some other resources for these lower acuity transports that really don't require a really highly trained crew. We kind of need those crews, at this point. Especially Labor wise, to be able to take those super sick people to Boston. We're at a point, and I'm a little bit embarrassed to say this, but we're at a point where in some cases, and certainly it's safe to do it, but it makes you nervous where we're sending some folks to Boston by private car. Because we can get them there, we can get them to Brigham or Mass General for whatever specialized care they need there and we certainly wouldn't never send anybody that was you know unstable, but these are historically people that it would have required a fairly high level of EMS care on the way down. I don't think any of us think that's a good way to do this, so it just makes me wonder how far we need to explore? Do we reengage and rethink about what EMS perhaps looks like a little bit in the past where lower acuity transports, if you have the human resource, really just require lower levels of training and that's not to suggest that's substandard, it's just the matching of the training level and the resource with the acuity of the patient. And then do we sort of redeploy the most highly trained cadre to where those acute patients are because I definitely think that there's, even in as an EMS educator, there's certainly been a drift towards higher training levels and sort of more interventional skills in the field and really what we need is for qualified people to match up with the patients and get them where they need to be.

Robert Hillman: Yeah and then look and see if that underpinning sets of statutory rules and regulations and administrative controls that have been layered on top that drive all of the processes now are creating roadblocks to get to where you just described.

Rob McGraw: I think we need to bring back in the hospitals have be part of this conversation. I can send a crew, we'll get a call from Presque Isle or Caribou, they will ask for a basic crew. I'll send a basic crew up there, they show up there and their on three different drips. Because the hospital is just flat out saying, well, we need a crew up here, we need a basic crew and the phone game or four or five people trying to find one ambulance. And then I'll send a crew up there, and as a paramedic crew, a PIFT crew, for the driver they're taking a bls trip, because the hospital just flat out said I need a paramedic now we're not matching that skill level with the acuity of the patient. I feel, again, we have to reeducate the hospital of what each level can do and does that patient really need to have a paramedic. All of our paperwork that keeps saying "Well, if the patient crashes", Any patient can crash. Any patient can have a significant medical event that takes place even if they are a BLS patient to a very sick patient. But they have this idea of we ask for a paramedic, we get it. There's no nothing else, we need to worry about so now we're taking that skill set out of the pool and put it in best medium for a 13-14 hours for it and it's a misappropriation I think.

John Martel: When those calls come into you who is making that primary requests? What personnel and what are what is their training level?

Rob McGraw: Our setup is we've got an EMS provider working our main phone line. And if we're getting a call from one COM or from a hospital they've got a list of questions they ask. What interventions are going on? What interventions been going on in the past three hours? so as the patient just came off Levophed. And you know we look at the possibility of going back on something. And then they triage it to ask what level is the lowest level we could possibly send because I can get an advanced crew or basic out the door in five minutes, it may take me 45 minutes to 90 minutes to get a medic crew out the door. So we do put these people through a medical triage and they're all EMS providers, we don't have non providers fielding calls. But we show up a lot in the hospitals and at one point, our service was the long-haul truckers of Maine, we went all over the state. And I've brought everyone in because many of our trips were not paid for because medical necessity was not met. Or we'd send a basic crew up to Presque Isle or Fort Kent and it was a medic trip, so now we have to take that manpower, pull it back to base and send up a medic crew, were three hours from Fort Kent so you now have six hours invested in not moving a patient before you even move them anywhere. So, bringing the hospitals in or going to a centralized patient movement dispatch center type deal where it's all the same information and they can track it better. At least that's what i'm getting from my end. I don't know what the other services feel with what information they are given.

John Martel: I can definitely see that from the hospital and because I will say that the, and I can't really speak for the nursing world, but from the physician world very few physicians are EMS physicians or have any training or any prior background in Fire or EMS, transport, etc. And we've had a number over the years of calls from abroad in the state where there was kind of a demand for air transport and you go through the case, and you sort of have to talk folks off the ledge that this is actually going to be just fine, this is the level of care that's appropriate. There's a number of patients in the last five years that have come down to Portland and literally been discharged within an hour of getting there where there had been a request for a helicopter transport, and so you can imagine, at every level from resources to finances to strain on the family kind of what that looks like, so I would agree, and you know I'm glad you explained who fields the calls for you. My other question is who is calling, is it is it physicians, is it nursing, is it clerical staff? Who is the primary point of contact from those hospitals?

Rob McGraw: A lot of times clerical . Occasionally, for some of the hospitals, the doctor will call directly because they'll say well I'm the doctor I need to get this person moved instead of what the medical necessity is. So we get a variance, but a lot of time it's a non-clinical clerical person just trying to find an ambulance to get them from point A to Point B with limited information.

John Martel: And really knew that's what you were going to say but that's kind of what I expected.

Joe Kellner: I guess from the medcom perspective that handles the one call program that Rob's talking about. You have 13 hospitals now that utilize us is kind of a central point of coordinating and officially transfer. And by and large it's a non-clinical person requesting the transport. They've kind of gotten used to the questions we ask and information we need but frequently we find the clinical acuity of the patient doesn't match the request. One way or the other, quite honestly.

Joe Kellner: Okay, we did talk about an every two week meeting frequency. I would love to get that on the books and I would propose for our next meeting at to look at to start. How is this time for folks, by the way, let me just ask it that way? So if we say 10 to 1130 every other Tuesday and the next meeting would be, my goodness, the 31st of May. Everybody good with that? Perfect all right. Darren did you catch that?

Davis, Darren W: yeah I caught, it will make it.

f. Establish Meeting frequency and schedule
    i. Joe Kellner: Okay, we did talk about an every two week meeting frequency. I would love to get that on the books and I would propose for our next meeting at to look at to start. How is this time for folks, by the way, let me just ask it that way? So if we say 10 to 1130 every other Tuesday and the next meeting would be, my goodness, the 31st of May. Everybody good with that? Perfect all right. Darren did you catch that?

    ii. Davis, Darren W: yeah I caught, it will make it.

g. Chair Position
    a. Joe Kellner: All right, another item, I want to touch on. I looked behind me, nobody was standing there, so I kind of became the de facto chair of this committee. I would be more than happy to pass it along to anybody who had interest in that. You don't have to speak up right now but … You know don't all speak up at once … but you can let me know offline if you're interested in that position. I would be more than happy to pass the torch on. I don't want that to reflect on how important I think this work is. We'll leave it at that, for now, unless anybody has anything they want to add in closing.

8. New Business

a. None

9. Action Items

- [ ] a. Joe Kellner to distribute the Massachusetts cost reporting tool
- [ ] b. Joe Kellner to distribute LD 2105 materials.

10. Next Meeting

a. Tuesday May 31, 2022 10:00 AM - 11:30 AM
b. https://mainestate.zoom.us/j/89157735650

11. Adjourn

Joe Kellner: Absent that, I would look for motion to adjourn.

Rob McGraw: Motion to adjourn

Robert Hillman: I'll second.